Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
PO BOX 9705
MCALLEN TX 78502-9705

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-3976-01

MFDR Date Received
July 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We called on 8/20/10 and spoke with adjuster Tracey Bock @800-328-0166 extension 222 and said that she approved wound care for patient. Upon our conversation with Tracy Bock on 10/11/10 she indicated that she had notes that she spoke with Carmen from our hospital and informed us that it was okay for service because claim had been accepted, however she was not aware that service required authorization."

Amount in Dispute: $1,951.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill for additional review and it remains in process at this time. We will submit a supplemental response upon completion of the pending review."

Response Submitted by: Gallagher Bassett Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19 through 30, 2010	Outpatient Wound Care	$1,951.46	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 23, 2010

- 19 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

Explanation of benefits dated April 21, 2011

- 19 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
- 19 – (197) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.

Issues

1. Did the respondent support the insurance carrier's reason for denying disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services in dispute with reason code 19 – (197) "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." No documentation was found to support a medical emergency, nor was any documentation found to support that these outpatient services had been preauthorized. The insurance carrier's denial reason is supported. Reimbursement is not recommended.

2. The requestor states they contacted the carrier on August 20, 2010. Per submitted documentation disputed services began August 19, 2010 prior to attempt to initiate prior authorization. Therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 9, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.